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Choices: An Evaluation of a Program Aimed at Reducing Criminogenic Thinking Among Incarcerated Women

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Choices: An Evaluation of a Program Aimed at Reducing Criminogenic Thinking Among Incarcerated Women

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This dissertation, written under the direction of the candidate's dissertation committee and approved by members of the committee, has been presented to and accepted by the faculty of the PsyD Program in Clinical Psychology in partial fulfillment of the requirements for the degree of Doctor of Psychology. The content and research methodologies presented in this work represent the work of the candidate alone.

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Dedication

This project would never have been completed without the unwavering support of my mother, father, brother, and uncles. My mom can always be counted on to pick up the phone when I call and is able to counsel me through the best and worst of times. My father pushes me to be the best version of myself and consistently checks-in with me to ensure I'm "being careful" and "taking care of myself". His hard work and dedication are undoubtedly why I have been able to come this far in my education. My brother is extraordinarily genuine and caring. He can be counted on to effortlessly incite unrelenting belly laughs, which were much needed in the process of writing this dissertation. My uncles are the most intelligent and playful people in my life. They offered me much needed respites filled with stimulating and challenging conversations that often culminated in tears of laughter. While the support of these people was imperative in my completion of this dissertation, my inspiration for embarking on this degree came from my grandparents. My grandparents taught me many lessons before their passing. Of the most important: to never give up and to always find the joy in life. My grandmother, the life of the party, was a bright, fashionable light in the darkest of rooms. My grandfather, a gentle giant, modeled perseverance, unconditional positive regard, and love for life and happiness. This is for them.

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Chapter 1

Introduction

The United States is the world leader in the number of incarcerated individuals (McVay, 2004). In the latest report published by the U.S. Department of Justice, Bureau of Justice Statistics, which includes data from the year 2016, it was estimated that there are 6,613,500 people under supervision of adult correctional systems in the United States (Kaeble & Cowhig, 2018). Between the years 1990 and 2016, the population of incarcerated women doubled (Aiello, 2016) and from 2008 to 2018 it was reported by the U.S. Department of Justice, Bureau of Justice Statistics that the adult female jail population grew by 15% (Zeng, 2020). As of March 2020, it was estimated that there is a total of 115,100 women in jail in the United States (Zeng, 2020). Women are the fastest growing group of incarcerated people and are more likely than men to have custody of their children (Aiello, 2016). Some studies show that two thirds of incarcerated women are mothers (Sandifer, 2008). Not only are we incarcerating people at alarming rates, those that were once incarcerated recidivate at alarming rates as well (National Institute of Justice, 2005). The impact of incarcerating women (or anyone for that matter) at this rate is alarming, and interventions to address recidivism and propensity to thrive post-release are imperative.

A 2014 study published by the National Institute of Justice revealed that within three years of release, 67.8% of the 404,638 prisoners in 30 states in 2005 were rearrested. The same study showed that within 5 years, 76.6% were rearrested. In 2013, 34.9% of California women recidivated while 46.4% of men did. After two years, 44.9% of women recidivated and 58.3% of men did. In United States and in California, there is a positive correlation between number of

years outside of prison/jail and likelihood of recidivism (California Department of Corrections and Rehabilitation, 2013).

There are many factors that influence recidivism. Some of these factors include criminogenic thinking (Walters & Cohen, 2016), substance abuse (Wilson, Draine, Barrenger, Hadley, & Evans Jr., 2013), employment status, friends, marital/family cohesion, and psychological and community functioning (Greiner, Law, & Brown, 2015). Those with co-occurring psychiatric disorders are about 40% more likely than those with only one diagnosis or none to recidivate (Wilson, Draine, Barrenger, Hadley, & Evans Jr., 2013). In fact, one third of women that are incarcerated are there with drug related charges (Berger & Powers, 2015). Approximately 80% of adults in jails and prisons in the U.S. have a history of substance abuse (Kubiak, 2004) and a high percentage of individuals recidivate. Therefore, it is important to understand the effectiveness of programs aimed at reducing substance use and criminogenic thinking (Kubiak, 2004; Mukku, Benson, Alam, Richie, & Bailey, 2012; Scott, Dennis, & Lurigio, 2015). It is widely understood that the incarcerated population is a severely underserved one. The aim of this dissertation was to highlight the strengths and weaknesses of a program within a jail that aims to reduce criminogenic thinking and curb problematic drug/alcohol use among women. This was done by conducting a literature review, analyzing qualitative and quantitative data, and making recommendations for program development.

Chapter 2

Literature Review

To address the factors that increase the chances a person will recidivate, many jails are adopting in-jail treatment programs. Some of these programs include contingency management, cognitive behavioral therapy, motivational interviewing, 12-step programs, confrontation therapy, and screening, brief intervention, and referral to treatment (SBIRT). The Choices program, the program to be evaluated in this dissertation, at the San Mateo County Jail encompasses all of these treatment modalities (and more) in various capacities. This literature review will start by summarizing some of the factors that contribute to recidivism, it will describe criminogenic thinking and its role in recidivism, it will discuss evidence-based treatment modalities for co-occurring disorders used in forensics and in the community, and finally it will briefly review other programs instituted in correctional settings

Factors Contributing to Recidivism

Some of the factors that contribute to recidivism include age, criminogenic thinking, type of offense, no custody of children, substance use frequency, and number of substance abuse problems (Scott, Grella, Dennis, & Funk, 2016; Scott, Grella, Dennis, & Funk, 2014). These factors can be put into two categories: static and dynamic (Gendreau, Little, & Goggin, 1996). Static risk factors include age, gender, ethnicity, criminal associates, and type of offense. Dynamic risk factors include what is commonly referred to as "criminogenic needs" (Gendreau, Little, & Goggin, 1996). Criminal cognitions, behaviors, and values are examples of criminogenic needs.

Of the static risk factors, age plays a major role in the likelihood that someone will recidivate. The literature suggests that the younger a person is when they are first incarcerated,

the higher the likelihood they will recidivate (Durose, Cooper, & Snyder, 2014; Piquero, 2015). In a report by the U.S. Department of Justice (Durose, Cooper, & Snyder, 2014), the following demographics are identified as being at higher risk for recidivism: male gender, violent offenses, African American ethnicity, and higher number of criminal associates. In addition, Of the dynamic risk factors, criminal thinking has been linked most closely to recidivism. Criminal thinking has been described as patterns of distorted thoughts that rationalize or support offending behaviors (Taxman, Giuranna Rhodes, & Dumenci, 2011). According to Taxman, Giuranna Rhodes, and Dumenci (2011), the concept of criminal thinking suggests that people whom are involved in a criminal lifestyle will endorse certain patterns of thinking that support their antisocial behaviors. The first time criminal thinking appeared in the literature was in an article published by Yochelson and Samenow in 1976. Yochelson and Samenow (1976) described criminal thinking as a concept which encompasses 36 thoughts and 18 resulting behaviors. One example they gave of a criminogenic thought is: "concrete thinking." Concrete thinking refers to thoughts that rationalize past behaviors as being unique rather than as part of a pattern. The work done by Yochelson and Samenow (1976) has provided much of the theoretical basis for the criminogenic thinking measures that exist (Taxman, Giuranna Rhodes, & Dumenci, 2011).

Criminal thinking patterns are associated with aggression, lack of empathy, impulsivity, violence, and disrespect for authority (Scott et al., 2014). It has been hypothesized that criminogenic thinking is inextricably linked to recidivism (Gendreau, Little, & Goggin, 1996; Scott et al., 2014; Scott et al., 2016). While there are some universal factors that increase the likelihood that someone will recidivate, research is yielding findings that suggest risk factors for recidivism are different for men and women. Despite the limited amount of research done on

women who recidivate; stress, depression, criminogenic thinking, childhood or recent abuse, and suicidality have been shown to predict recidivism (Scott et al., 2014).

Mental disorders also play a key role in recidivism. As many as 60% of inmates have mental health problems (Sadeh & McNeil, 2015). Co-occurring substance abuse predicts recidivism as does younger age of first offense (Constatine et al., 2010). It is estimated that nearly 1 million individuals with a serious mental illness are arrested every year (Constatine et al., 2010). It is very difficult to do research on recidivism because individuals often commit crimes in different counties/states and researchers are often limited from gathering data across counties/states. It is generally accepted that when someone has a diagnosis of a mental disorder they are at higher risk for recidivism and at an even higher risk when they have a co-occurring disorder (Carr, Baker, & Cassidy, 2016).

Criminogenic Thinking and Recidivism

Criminal thinking can be described as a pattern of antisocial attitudes/beliefs/values, criminal companions, and impulsivity. This pattern of thinking can be conceptualized by using three factors: (1) control over self, others, and environment (control); (2) self-pitying (cognitive immaturity); and (3) self-importance (egocentrism) (Mandracchia, Morgan, Garos, & Garland, 2007). The control type of thinking can be described as thinking you are all-powerful and have control over everything. Cognitive immaturity occurs when someone uses much self-pity and pays attention to only one portion of an event rather than the whole. Egocentrism can be described as a thinking pattern of pretentiousness, closed-minded, secretive, and superiority (Mandracchia et al., 2007). Before we delve into the relationship between criminal cognitions and recidivism, let us briefly review what fosters criminal cognitions.

There is a long-standing debate about whether nature or nurture is responsible for psychopathy. The research on the causes of antisocial or criminogenic thinking is no exception to this controversy. Many researchers and practitioners have adopted the theory that nature and nurture are both responsible for human behavior, and thus for criminogenic thinking and antisocial behaviors. Genetic factors play a complex role in behavior and personality that is not yet fully understood. Social, developmental, and environmental factors appear to have ability to override genetic factors in some cases. In one study that illustrates this potential, conducted on college students by Gonzalez, Mandracchia, Nicholson, & Dahlen (2014) criminal thinking (i.e., self-justification) and antisocial behaviors have been linked to restrictive and controlling parenting styles. In addition, warm parenting was shown to protect against criminogenic thinking (Gonzalez et al., 2014). Although we are not entirely sure about the cause of criminogenic thinking, current research is clear about its connection to recidivism which is to be described next.

Many studies have found a relationship between criminal thinking/cognitions and recidivism (Gendreau, Little, & Goggin, 1996; Mandracchia, Gonzalez, Patterson, & Smith, 2015; Walters & Cohen, 2016; Walters & Lowenkamp, 2016). The proposed association between criminogenic thinking and recidivism is a positive one- as criminogenic cognitions decreases, recidivism decreases. A meta-analysis of four studies utilizing the Psychological Inventory of Criminal Thinking Styles scale, found that criminal thinking is inextricably linked to recidivism and may, in fact, be a stronger predictor than criminal history (Walters, 2012). Walters (2012) indicated that people who have committed violent crimes are more likely than people who have committed non-violent crimes to recidivate; however, he also suggested that criminal thinking is a stronger predictor for recidivism than type of crime committed. Armed

with the knowledge that criminal thinking is a strong predictor of recidivism, treatment modalities have been developed and researched to decrease the occurrence and strength of this thinking style.

Frequently Used Treatment Modalities

According to a literature review performed in 2011, the major theories utilized in treating substance abusing individuals in jails/prisons in the United States are biopsychosocial, systems, and assets-based community development (Andrews, Feit, & Everett, 2011). Most commonly, Narcotics Anonymous and Alcoholics Anonymous meetings are offered to inmates attempting to gain and maintain their sobriety (Andrews, Feit, & Everett, 2011). There is a lack of efficacy studies on substance abuse treatment in jails and prisons (suggesting that this is an underserved, vulnerable population). Secondary to this lack of research, we turn to understand substance abuse treatment programs outside jail/prison that have demonstrated positive change. Evidence-based treatments (EBTs) for substance use disorder (SUD) include: contingency management; 12-step programs; cognitive behavioral therapy; motivational interviewing; screening, brief intervention, and referral to treatment (SBIRT); and Seeking Safety (Manuel, Hagedorn, & Finney, 2011). Another treatment that has been used historically is confrontation or attack therapy. And now, a short review of the aforementioned treatment modalities.

Contingency management uses operant conditioning to curb drug usage (Benishek et al., 2014). An incentive is awarded to the person based on drug/alcohol abstinence. Contingency management has been shown to be effective in the short term, but efficacy decreases after six months (Benishek et al., 2014).

Twelve-step programs, like Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), require participants to "work the 12-steps" to obtain and maintain abstinence from the

target maladaptive behaviors. AA/NA meetings do not aim to reduce criminogenic thinking and instead aim to reduce problematic drug/alcohol use and abuse. The 12-steps are: (1) admitting powerlessness over the addiction; (2) believing in a higher power; (3) turning your will and lives over to a higher power; (4) completing a moral inventory; (5) admitting your wrongs; (6) be ready to have the higher power remove your wrongs; (7) asking the higher power to remove your shortcomings; (8) make list of those you have harmed; (9) making amends to those you have harmed; (10) admitting wrong in the present; (11) praying; and (12) continuing to practice the previous steps (Bob, 1973). Research on 12-step programs have found mixed results. This is partially due to the fact that 12-step programs are particularly difficult to research (Krentzman, 2007). Barriers to researching 12-step programs include but are not limited to: lack of longitudinal data secondary to complete anonymity of participants, ethical concerns of having a control group, fluid membership boundaries, variability between AA/NA meetings, and self-selection as it accounts for motivation for change (Krentzman, 2007). Some studies show that 12-step programs are ineffective or harmful (Miller, 2008), while other studies demonstrate that 12-step programs are an effective, cost-efficient way to maintain sobriety (Fiorentine, 1999; Krentzman, 2007). The research is mixed on AA/NA treatment, but these groups have successfully treated millions of people worldwide and its popularity remains constant over decades (Krentzman, 2007).

As described by Craske (2010), cognitive behavioral therapy (CBT) is problem-focused and aims to change maladaptive thoughts, emotions, and behaviors. Cognitive behavioral therapy's hallmark feature is the belief that thoughts, behaviors, and emotions are linked- known as the cognitive triad. A CBT therapist adheres to the idea that thoughts influence behaviors which influence emotions, and vice versa. CBT is often used in SUD treatment to identify the

thought/emotion that precedes the problematic drug/alcohol use. By identifying and challenging the preceding thought/emotion, it is believed that it is possible to change the maladaptive behavior. It is also believed that by decreasing the frequency of the maladaptive behavior, the frequency of the negative thoughts and emotions will decrease as well. A meta-analysis conducted by Lipsey et al. (2001) of 14 studies on adult and adolescent offenders identified that CBT helped decrease the rate of recidivism by more than 50% as compared to the control group. In addition, another meta-analysis showed that people who did not receive CBT had 1.53 times greater odds to recidivate than those who did receive CBT (Landerberger & Lipsey, 2005).

Motivational interviewing was initially developed to aid people with their problematic drinking (Moyers & Houck, 2011). Its focus is collaborating with the patient to elicit change talk and motivation for change. The theory is that if the interviewer can successfully elicit change talk by exploring ambivalence and developing discrepancy between their behaviors and their goals, then the person will inherently be more motivated to alter their maladaptive behavior. Motivational interviewing has been found to reduce problematic drinking in adolescents and adults (Kazemi et al., 2013; Vasilaki, Hosier, & Cox, 2006). It also has been shown to reduce blackouts in college freshman (Kazemi et al., 2013). Further, research on Motivational Interviewing has offered evidence of its efficacy to treat co-morbid disorders and increase medication adherence (Satre, 2016; Spoelstra, Schueller, Hilton, & Ridenour, 2015)

Screening, brief intervention, and referral to treatment (SBIRT) is an EBT commonly used in medical facilities. SBIRT is a comprehensive screening tool for alcohol and drug abuse. It also includes brief interventions- motivational interviewing, skills building, etc. At the end of the contact with the client, referral to treatment is made if indicated. Research on SBIRT shows that it is effective in the short-term to help people mitigate their maladaptive behaviors; however,

there is little information about its long-term effects at this time (Babor et al., 2007). In addition, SBIRT has been shown to be cost-effective and efficient in diagnosing and referring people with substance use disorders (Dwinnells, 2015).

Seeking Safety is a cognitive behavioral treatment protocol that aims to address comorbid posttraumatic stress disorder (PTSD) and substance use disorder (SUD) (Najavits, 2001; Zlotnick, Najavits, Rohsenow, & Johnson, 2003). The Seeking Safety treatment manual aims to address 25 topics that are grouped into five central ideas (Zlotnick et al., 2003). These five central ideas are: (1) safety as priority of first-stage treatment; (2) integrated treatment of PTSD and substance abuse; (3) a focus on ideals; (4) four content areas: cognitive, behavioral, interpersonal, and case management; (5) attention to therapist processes (Najavits, 2001). The primary goal of Seeking Safety is to promote abstinence from use of drugs/alcohol and to promote personal safety. It has been found that Seeking Safety can decrease rates of recidivism among formerly incarcerated women, decrease rates of relapse, and decrease symptoms of PTSD (Zlotnick et al., 2003).

Confrontation therapy or attack therapy first emerged in the treatment of addiction in the 1960s (White & Miller, 2007). It is a type of therapy in which the clinician addresses the patient's thoughts, feelings, and behaviors in a confrontational manner. In the literature review conducted by White and Miller (2007), these interventions varied greatly in intensity- ranging from "frank feedback to profanity-laden indictments, screamed denunciations of character, challenges and ultimatums, intense argumentation, ridicule, and purposeful humiliation" (pg. 2). This shift in treatment style from client-centered approaches are thought to be secondary to change in theoretical ideas of the cause of addiction. During the 1920-1950's, there was a theoretical shift from believe that addiction was caused by biological factors to being caused by

characterological flaws (White & Miller, 2007). Thus, it was thought confrontation of characterological flaws would cure the person of their addiction. In January 1958, a man named Charles Dederich began hosting his own AA meetings after maintaining less than a year of sobriety via participation in AA/NA in Southern California. His boisterous meetings for others attempting to obtain and maintain sobriety became quickly popular. Eventually, he began renting out his own space for these meetings. As popularity of these meetings continued to grow, he established the first recovering-addict ran therapeutic community called "Synanon" in September 1958. While a complete review of rise and fall of Synanon is beyond the scope of this dissertation, it is important to note that it was one of the first therapeutic communities to utilize intense confrontation as an intervention to curb problematic drug/alcohol use. Some of the interventions they used are as follows: "pull-ups" (immediate peer-to-peer feedback to highlight problematic behaviors), "haircuts" (confrontation during which a newer member is dismantled by a more senior member and given advice on how to ameliorate problematic behaviors), and the "Synanon Game" (a group in which verbal attacks are used to break down a person's exterior image and defenses while, theoretically, building them up on the inside). The goals of these interventions and "the game" were to provide an outlet for emotional reactions/experiences so that you are free to act responsibly and mindfully outside of "the game". Once Synanon was dismantled by the government, leaders of this group migrated to San Francisco to found Delancey Street.

Older research on the efficacy of attack therapy illustrates it in a positive light. More contemporary research does not. For example, one study conducted in 1974 on people compared outcomes of a treatment as usual group vs. attack therapy groups in an alcohol use disorder inpatient program (Balgooyen, 1974). Results showed that the 6-week Synanon-inspired attack

therapy group was more effective than the 6-week treatment as usual group (Balgooyen, 1974). It has also been suggested that the efficacy of confrontation efficacy depends on treatment setting, philosophy, characteristics of the patient, patient beliefs about the confronter, and level of emotional intensity in the attack (Polcin, 2003). Conversely, some researchers have found that confrontation or attack therapy is counterproductive and some even find it unethical (Miller et al., 1993; Polcin, 2003; White & Miller, 2007). Now that we are aware of some of the treatment modalities that have been implemented historically and currently, let us review where and how they are being implemented in forensic settings today.

Treatment Programs

The U.S. criminal justice system has become an institution that houses many people who have a mental illness and provides less than optimal support for rehabilitation. In an attempt to address this, some county jails are attempting to reduce recidivism and substance use through inpatient-like programs. Some examples of substance abuse programs across the United States include: Stay'n Out (New York), KEY/CREST (Delaware), New Vision (Texas), and Free and Amity (California). These programs all aim to help inmates gain sobriety and prevent relapse (Delaware KEY/Crest Substance Abuse Programs, 2011; Knight, Simpson, & Hiller, 1999; Stay'n Out, 2016; Turner et al., 2006). The treatment at these facilities is designed to restructure maladaptive cognitions and teach adaptive coping skills (KEY/Crest Substance Abuse Programs, 2011; Knight, Simpson, & Hiller, 1999; Stay'n Out, 2016; Turner et al., 2006).

In New York County Jail, the Comprehensive Alcohol and Substance Use Treatment programs (CASAT) was legislatively mandated to be developed. CASAT ensures that inmates receive substance use treatment and prepares them to re-enter into the community. CASAT has three phases. The first phase is an intensive, six-month residential treatment program. Phase II is

called "community reintegration" which involves reintegrating the inmate into society and is on an outpatient basis. The third phase, "aftercare," transitions inmates to the community and connects them with ongoing care. Inmates are often mandated to participate in this program (NYS Department of Corrections and Community Supervision, n.d.).

In California, Sisters in Sober Treatment Empowered in Recovery (SISTERS) and Roads of Recovery are in-jail treatment program addressing many facets of relapse/recidivism prevention (Health Right 360, 2016; Jail-Based Rehabilitation Programs, 2016). SISTERS targets criminogenic thinking, relapse prevention, re-entry into society, stress reduction, self-esteem building, anger management, and much more. A program of Health Right 360, SISTERS, emphasizes continuity of care and case management.

Now that we have reviewed literature on recidivism, frequently used treatment modalities for co-occurring disorders, and some treatment programs in existence today, we can begin to discuss the data gathered for this program evaluation and the subsequent recommendations that will be made.

Chapter 3

Methodology

Overview

This study analyzed archival data and employed qualitative interviews to evaluate the effectiveness of an in-jail substance abuse treatment program, "Choices". This was done via secondary data analysis of the scores on the TCU-CTS, TCU-ENG, and PHQ-9 (all of these measures are described below); information gathered from a demographic survey (Quantitative assessment); and semi-structured interviews (Qualitative assessment). The study's quantitative data were collected pre- and post-participation in the program by Choices counselors, and was conducted in Redwood City, California at the Maple Street Correctional Facility between the years of 2016 and 2018. Interviews were conducted in and out of the jail, all in private settings after obtaining informed consent. This study hypothesizes that criminogenic thinking will decrease, depression scores will decrease, and treatment engagement will increase as a result of participating in Choices. The qualitative interviews provided additional insight for program development and improvement. Institutional Review Board (IRB) approval was obtained at the University of San Francisco and a copy of the approval was provided to our study site.

Setting

The Choices program at the San Mateo County Jail is modeled after a drug treatment program "Delancey Street" that originated in San Francisco. Choices was one of the first replications of Delancey Street. In line with Delancey Street's goal, the goal of Choices is to aid participants in gaining and maintaining a life of sobriety, filled with purpose and integrity. Delancey Street and Choices teach interpersonal skills, hygiene, and vocational skills. In addition, they require that everyone earns a High School equivalency degree. Complete Choices

program curriculum can be found in Appendix A. Both Choices and Delancey Street programs three main rules: no drugs/alcohol, no physical violence, and no threats of violence. In like with Delancey Street, Choices' programming includes "issues groups" and development of vocational skills. In addition to this, Choices also offers Cognitive Behavioral Therapy (CBT), Alcoholics Anonymous (AA), and Narcotics Anonymous (NA) meetings. CBT groups include going over cognitive distortions and the cognitive triad. In the AA/NA groups, members are requested to "work" the 12 steps and participate in speaking to the group. All members of Choices are encouraged and expected to enter into a treatment program upon release from jail. The goal of Choices is to decrease recidivism by lowering criminogenic thinking and increasing the repertoire of coping skills each inmate possesses. The Choices program houses women (and men, separately) that identify as having a substance use disorder. The women that apply to be housed on the Choices pod are required to fill out a short questionnaire describing their drug history, reasons for wanting to enter the program, and to describe their motivation to change. Choices staff then interviews them for goodness-of-fit assessment. If women are admitted to the program, they are allowed to "roll-up" or exit the program at any time. As shown in Appendix A, day-to-day activities range from CBT and DBT group therapy, narcotics anonymous meetings, alcoholics anonymous meetings, parenting classes, making quilts for the homeless, and "issues groups." In the "issues groups", participants are to expose the behaviors that their peers engage in that inhibit their ability to stay sober or increase the likelihood that they will recidivate. The inmates are encouraged to give advice, keep others accountable, and "own up" to their problematic/maladaptive behaviors.

Qualitative Assessment

Procedure. The qualitative assessment consisted of semi-structured interviews with 5 former Choices inmates and 5 current Choices inmates. The interviews aimed to assess strengths and growing edges of the program from the point of view of the current participant and former participant. Interviews were conducted in private rooms and took, on average, 45 minutes per interview. Prior to the start of the interviews, a consent form was reviewed and ample time to answer any questions about the study was provided. See Appendix B for consent form. All interviews were audio recorded with consent from the participants (see Appendix C for interview guide). Participants did not receive compensation for their participation in the study as compensation for inmates is not permitted by the jail institution. Interviews were then transcribed and analyzed to ascertain common themes

Participants. Participants were referred to the study via current Choices counselors. The current Choices counselors referred the current inmates and former inmates to this voluntary study because they already had contact information and access to these women. To be included in this voluntary study, participants required to be: English proficient, have participated or are currently participating in the Choices program, and be able to provide informed consent. Individuals were excluded if they were not willing to be audio recorded and had not been in the Choices program for over a month. Of the participants that were contacted for the interviews, none met criteria for exclusion. There were more referrals for interviews than interviews that took place, further protecting the anonymity of the interviewees. No demographic data were collected from the interview participants to protect their anonymity. No direct quotes were used from the interviews to protect their anonymity and confidentiality.

Measures. Semi-structured interviews were conducted to determine strengths and growing edges of the Choices program. The questions were designed to gleam insight into parts

of the program that participants felt were helpful, felt were not so helpful, and felt should be added to the curriculum. See appendix C for interview guide.

Data Analysis. Interview data were analyzed using the thematic analysis approach (Braun & Clarke, 2006). First, interviews were coded to ascertain themes related to the strengths and weaknesses of the program. Then, axial coding was employed to group the themes into categories. Lastly, selective coding was used to enable us to discover what the strengths and weaknesses are of the program.

Quantitative Assessment

Participants and Procedures. These data were drawn from existing, anonymous administrations of the Texas Christian University Criminogenic Thinking Scale (TCU-CTS), Texas Christian University Treatment Engagement Scale (TCU-ENG), Patient Health Questionnaire (PHQ-9), and demographic surveys. The TCU-CTS, TCU-ENG, and PHQ-9 were administered by Choices counselors at the beginning (pre-) and end (post-) of the inmate's participation in the program. The demographic survey was only completed upon entry into the program as the variables on that survey were likely no subject to change. The female, adult inmates who participated in this program did so on a voluntary basis and were interviewed for goodness-of-fit. Length of stay in the program typically varies from a few weeks to years. The data used in this project included data collected from 2016-2018. The purpose of this quantitative analysis is to assess changes in criminogenic thinking, treatment engagement, and depression as it has shown to be related to likelihood of recidivism (Gendreau, Little, & Goggin, 1996; Mandracchia, Gonzalez, Patterson, & Smith, 2015; Walters & Cohen, 2016; Walters & Lowenkamp, 2016).

Measures. Demographic information was collected via self-report upon entry into the program. Upon admission into the program, participants were asked to anonymously complete the TCU-CTS, TCU-ENG, and PHQ-9. They were also asked to complete these measures upon discharge from the program.

Texas Christian University Criminogenic Thinking Scale. The Texas Christian University Criminogenic Thinking Scale (TCU-CTS) is broken down into six subscales: (1) justification; (2) entitlement; (3) power orientation; (4) cold heartedness; (5) criminal rationalization; (6) and personal irresponsibility. Justification (JU) is described as a thinking pattern that is characterized by a minimization of the significance of the criminal acts and its validation based on external factors. A high score on the entitlement scale (EN) would signify a person's belief that they have privilege and a misidentification of wants for needs. Power orientation (PO) is illustrated by a need of control and power. The cold heartedness (CH) scale measures emotional connection in relationships with others. Criminal rationalization (CN) addresses a relatively negative attitude toward authority figures and the law. Personal irresponsibility (PI) measures the level to which an offender accepts their role in the criminal offense. This measure requires that subjects respond to statements on a likert scale- ranging from 1-5, or strongly disagree to strongly agree. The responses are then tabulated by obtaining the mean score for each subscale and multiplying the mean score by 10 to obtain a score between 10 to 50, higher scores reflect higher levels of criminogenic thinking. According to Knight et al., 2006, the TCU-CTS has good psychometric properties and can be used as a cost-effective, quick way to measure criminogenic thinking patterns. Knight et al. (2006), demonstrated that its test-retest reliability averages at .74, and its Chi Square goodness of fit score was statistically significant ($p < .01$). It has been shown to have good internal consistency and test-retest

reliability. In addition, its intercorrelations are good; however, the Knight et al. (2006) study showed that there was not a statistically significant relationship between CH and JU, CN, and PO. The full TCU-CTS can be found in Appendix D.

Texas Christian University Treatment Engagement Scale. The Texas Christian University Treatment Engagement Scale (TCU-ENG) is a 36-item measure broken into four scales: treatment participation (TP), treatment satisfaction (TS), counseling rapport (CR), and peer support (PS) (Simpson et al., 2012). The TP scale includes 12 items and has high reliability (.86 in criminal justice-based settings). An example of a TP item is: "you are willing to talk about your feelings during counseling." TS is measured in 7 items and has a .79 reliability in criminal justice-based environments (Simpson et al., 2012). An example of a TS item is: "you are satisfied with this program." CR consists of 12 items and has the highest reliability of all the scales .93 in criminal justice-based environments (Simpson et al., 2012). "You trust your counselor" is a sample item of the CR scale. PS is measured in 5 items and has the lowest reliability of all the scales in a criminal justice-based environment at .77 (Simpson et al., 2012). One of the PS items includes "other clients at this program care about you and your problems." The TCU-ENG scale can be found in Appendix E.

Patient Health Questionnaire. The Patient Health Questionnaire-9 (PHQ-9) is a 10 item self-report, Likert scale measure that assesses presence and severity of depressive symptoms. It has been widely studied and is largely accepted as having criterion validity, construct validity, and external validity (Kroenke, 2001). Cutoff scores for the PHQ-9 are as follows: 1-4 indicates minimal severity of depression symptoms; 5-9 reflects mild symptoms of depression; 10-14 is indicative of moderate symptoms of depression; 15-19 is suggestive of moderately sever

symptoms of depression; and scores 20-27 suggests severe symptoms of depression (Kroenke, 2001). The PHQ-9 can be found in Appendix F.

Demographic survey. A demographic survey was provided to each inmate upon intake to Choices and gathers data on the following variables: age, ethnicity, marital status, number of children, level of education, employment status, drug of choice, gender identity, sexual orientation, number of incarcerations, number of Choices enrollments, type of insurance, and category of accused crime. The demographic survey provided to Choices participants can be found in Appendix G.

Data Analysis.

Three separate mixed-effects ANOVA models were conducted in R to test the hypotheses that overall criminogenic thinking decreases from intake to discharge, treatment engagement increases from intake to discharge, and depressive symptoms decrease from intake to discharge. Mixed-effects ANOVA is a statistical technique that is used to analyze within subjects pre- and post-scores while simultaneously analyzing between subjects pre- and post-scores while accounting for various demographic variables. We used the "lmer" function from the R package "lme4" to fit these models (Bates, Machler, Bolker, & Walker, 2014). These models were fit as follows:

$$\text{score}_j = \beta_0 + \beta_{1j}(\text{time point}) + r_{ij}$$

R code: anova(lmer(score ~ time point + (1|subject ID)))

where time point (intake vs. discharge) was dummy-coded, β_{1j} is the main effect of time point, and r_{ij} is the random effect of each participant's intercept. We used Satterthwaite approximations of degrees of freedom, which can result in fractional values. For tests of the primary hypotheses, we used Bonferroni correction of to control for the type I error rate, setting

$\alpha = .017$. In addition, we conducted exploratory analyses in which we tested whether participant age (18-25 years, 26-40 years, 41-64 years), marital status (single vs. married), race (white vs. non-white), ethnicity (Latina vs. non-Latina), and education (ordinal variable) interacted with time point to predict change in treatment engagement, depressive symptoms, or criminogenic thinking from intake to discharge. In the presence of a significant interaction, we conducted follow-up contrasts.

Chapter 4

Qualitative Results, Discussion, and Limitations

The purpose of this dissertation was to determine what some of the strengths and weaknesses are of the Choices program. The following aspects of the groups in the program were identified as helpful by current and former participants: 1) Seeking Safety groups (which includes sub-topics such as boundaries and trauma), 2) social justice psychoeducational groups, 3) parenting groups, and 4) groups building insight through "issues groups" (a term used by Choices to describe confrontation/attack therapy groups). Areas of growth discussed in interviews with current and former participants of the Choices program included: 1) attack/confrontation therapy or "issues groups", 2) lack of group cohesion, 3) the peer-ran nature, and 4) not enough time alone.

Strengths

Seeking Safety. Seeking Safety is a cognitive behavioral treatment protocol in which participants are guided to focus on five content areas: 1) establish safety, 2) treatment of PTSD and SUD, 3) focus on ideals, 4) treatment in cognitive, behavioral, interpersonal, and case management, and 5) attention to therapist processes. Of the women interviewed, themes arose about how Seeking Safety was an effective group in building coping skills and identifying triggers. Studies have been conducted supporting the effectiveness and efficacy of Seeking Safety groups with incarcerated women. Wolff, Frueh, Shi, and Schumann (2012), demonstrated in their study of 74 incarcerated women that Seeking Safety was found to be effective through both quantitative and qualitative data analyses. Overall, there is much support in the literature for the effectiveness of Seeking Safety in jail/prison populations to lessen the severity of symptoms

of PTSD and substance use disorders (Lynch, Heath, Matthews, & Cepeda, 2012; Wolff et al., 2012; Zlotnick, Najavits, Rohsenow, & Johnson, 2003).

Social justice group. All participants identified the Social Justice group as a helpful aspect of Choices because it informed them how systematic racism works and educated them about historical injustices that have occurred in the United States. In interviews with the women, the group was identified as thought provoking and interesting. It was described as helping the women understand the social ladder and their place on it. The social ladder is a concept that describes how people can be placed on a metaphorical ladder based on various identities-essentially, that some are higher or "better" than others on the metaphorical ladder (Schnittker & Bacak, 2013). It was discussed by the women that by understanding their place on the social ladder following incarceration, it helped illuminate their untapped potential for the future and how stereotypes may influence their release planning. The Social Justice group appears to build a sense of social upward mobility. The belief in social mobility either up or down the social ladder has been shown to be related to decreased anger with subjective social status (Sagioglou et al., 2019). While decreased anger or frustration with perceived low social standing may be beneficial in the moment, it also decreases probability of political change to address the standing of a particular group on the social ladder. The decreased probability of political change to the social ladder is secondary to the apathy that can occur when a group of people minimize the power the established social ladder has and accept the current zeitgeist (Day & Fiske, 2017; Sagioglou et al., 2019). Low subjective social status has been linked to negative health outcomes including, but not limited to, obesity, depression, perpetuation of violent crimes and substance abuse, smoking, anger, and cardiovascular risk (Michelson, Riis, & Johnson, 2016; Wolff, 2009). The need or lack of need to include social justice psychoeducation (including the concepts of the

social ladder and social mobility) in the Choices programming relies on which is more beneficial to the inmate- immediate decrease in anger/hostility or possibility of overall societal change. While the decrease in anger/hostility the inmate may experience may be short-lived and motivation to improve their subjective social standing may increase, the possibility of societal change may present with opportunity for cultural shift.

Parenting group. Parenting classes were also identified as helpful by the women interviewed. Some of the women interviewed reported that they were mothers and felt that the class taught them effective parenting skills to use when they return to their families. There are many different types of parenting groups that have been developed ranging from psychoeducational to behavioral in nature. The types of parenting groups offered to Choices participants used more psychoeducational interventions as they often have limited (or non-traditional) capacity to parent from jail. To summarize what the women said who articulated receiving benefit from the parenting groups, it was stated that parenting groups helped build awareness around feelings of guilt for being incarcerated and not physically there to parent, how to establish healthy boundaries with their children, and what effective communication is. Research on psychoeducational parenting classes from jail illustrate a promising picture. Benefits of offering parenting classes to female inmates are as follows: reduces recidivism, improves social and interpersonal skills, improves mental health, and prevents criminal behavior in the children (Sandifer, 2008). Additionally, it can increase parenting knowledge, reduce rates of corporal punishment, and increase potential to allow for age-appropriate experiences that teach responsible behavior in their children (Miller, 2014; Sandifer, 2008). Overall, offering parenting education classes to inmates has been demonstrated to be effective in improving parenting skills and improving the wellbeing of the inmates.

Issues groups. Some women described "issues groups" as useful to help build insight into patterns of behaviors and reasons for engaging in those behaviors. "Issues groups" is a term that Choices participants and counselors use to call their confrontation/attack therapy groups. It's a group where they call out another participant's "issues." These groups are facilitated 1-2 times per week, or sometimes more, depending on need of the group as assessed by the Choices counselors. Of the women interviewed who supported the use of issues groups, it was discussed that getting "haircuts" provided opportunity to take a look at maladaptive behaviors and their triggers. As discussed in the literature review section of this dissertation, there are studies that demonstrate the effectiveness and studies that demonstrate the potential harmful impact that attack therapy can pose. One woman even summarized that issues groups can be and are helpful to some, but harmful to others depending on how sensitive they are to verbal berating. Research supporting the use of attack therapy assert that it builds interpersonal awareness and curbs maladaptive behaviors (Balgooyen, 1974). Yet, many women also identified "issues groups" as unhelpful and as something that should be removed from the program. Secondary to the literature demonstrating little empirical evidence for this type of intervention, and necessity of a group protocol to be generalizable to the needs of many, it is suggested that the use of issues groups be ended. Further rationale for this recommendation, as is informed by the literature review, will be expounded upon in the recommendations section of this chapter.

Weaknesses

Weaknesses discussed in interviews with current and former participants of the Choices program included: 1) attack/confrontation therapy or "issues groups", 2) lack of group cohesion, 3) the peer-ran nature, and 4) not enough time alone. Following the discussion of the weaknesses that arose in the interviews will be a section on recommendations for program development.

Issues groups. Of the interviews conducted, most participants reflected on "issues groups". Some of the women reflected on how it was not enjoyable but was helpful. And others reflected on how the "yelling" was not helpful and was counterproductive to their treatment goals. Some of the research on attack therapy demonstrates how, like with any treatment modality, it is imperative to match the patient with the appropriate type of treatment based on the individual's characteristics (Polcin, 2003). As in Polcin's 2003 article, the following characteristics were discovered to be necessary in establishing effective confrontation: patients must perceive the relationship with the practitioner to be trusting, confrontation must be focused on behaviors that lead to substance misuse, setting in which the confrontation takes place must be accounted for, and extreme expression of emotion must be avoided. Confrontation is not a dichotomous variable, and that should also be addressed. There are varying levels of confrontation and manners in which it is executed. In the interviews with former and current participants of Choices, "issues groups" were characterized by yelling and verbal attacks on the person and their behaviors. There was once a belief that confrontation or attack therapy was effective in curtailing problematic behaviors. Between 1920-1950, there was a shift in the belief of what causes addiction- from a more biological conceptualization to one that focused more on characterological flaws. In the 1960's, mental health practitioners theorized that the characterological flaws that were present in those struggling with addiction were caused by deeply repressed feelings. As a result, confrontation techniques emerged in an attempt to orchestrate a situation where the repressed emotions are evoked. There was a belief that the cure to addiction lied in the cathartic process of the patient releasing all of their repressed emotions and destroying their flawed and false inflated perception of self. One of the studies conducted on confrontation therapy in an attempt to provide supporting evidence for the intervention was

completed in 1974 (Balgooyen, 1974). The study participants were identified as chronic alcoholics obtaining inpatient treatment at the Palo Alto Veteran's Association in California. Participants were assigned into one of two treatment groups- treatment as usual and "Synanon model" of treatment (Balgooyen, 1974). Results of this study indicated that the participants receiving confrontation/attack style of the "Synanon model" treatment experienced greater improvement overall in their symptoms as compared to the treatment as usual group (Balgooyen, 1974). More research providing evidence demonstrating the efficacy of confrontation/attack therapy was unable to be located- likely due to the fact that the research is older, mostly in print, and thus widely inaccessible. Much of the research on confrontation and/or attack therapy, or interventions such as "haircuts" and "pull-ups", now demonstrate a negative impact on its participants (Polcin, 2003; White & Miller, 2007). In a review of over four decades of research on confrontation interventions, White & Miller (2007) found no clinical trials that illustrate the efficacy of confrontation and found much research on the harmful effects (especially in vulnerable populations.) In the literature on attack therapy's long-lasting effects, a study conducted in 1976 with subjects that were suffering from alcohol use disorder. They were provided with either behavioral, token economy therapy or intense confrontational therapy. The results of this study demonstrated that 50% of the people improved in their maladaptive behaviors whereas 0% of the people in the intensive confrontational therapy did (White & Miller, 2007). In another study examining the efficacy of attack therapy, it was shown that the dropout rate of participants receiving attack therapy was four times higher than the group receiving behavioral therapy (White & Miller, 2007). One study conducted with a sample of 137 subjects receiving inpatient alcohol treatment at a Veteran's Association in Dallas, Texas yielded findings that those who received treatment from an empathic staff with emphasis on building

self-esteem maintained sobriety at 12-month-follow-up were twice as likely to be sober than those who received confrontation therapy (White & Miller, 2007). The overwhelming majority of the research on attack-style therapies indicates that it no longer has the evidentiary support that it was once thought to have. Suggestions for program development in light of this research will be included in the recommendations section.

Group cohesion. Lack of group cohesion was identified as something participants wished would improve. Cohesion in a group can be defined as vertically and horizontally (Burlingame, McClendon, & Yang, 2018). Vertical group cohesion refers to the relationship the individual has with the facilitator while horizontal group cohesion refers to the relationship the individual has with the other individuals and the group as a whole (Burlingame, McClendon, & Yang, 2018). As it was not ascertained in the interviews with the Choices women which type of group cohesion they were referring to, for the purpose of this dissertation, we will operate under the condition that they were referring to both vertical and horizontal cohesion. The literature is very clear that the more a patient feels connected and understood, the more they will experience symptom reduction (Burlingame, Fuhriman, & Johnson, 2001). Additionally, the more a patient feels cohesion and relatedness in the group, the more likely they are to feel comfortable in the group and, thus, are more likely to disclose important information that will yield imperative group feedback that will aid their recovery (Burlingame, Fuhriman, & Johnson, 2001). Of the women interviewed, many reflected that they felt a lack of group cohesion in the milieu of the Choices program. Lack of group cohesion has negative impacts on group process and individual ability to decrease symptom severity. As it relates to group cohesion, common factors should be addressed and explored further in the interest of program development and development of group cohesion. Common factors is widely accepted as including the following therapeutic elements:

alliance, empathy, shared expectations of therapy outcomes, cultural adaptations of evidence based treatments, and therapist differences (Wampold, 2015). It is also widely accepted that common factors have a major influence on therapy outcomes (Brown, 2015). Some studies even assert that common factors may even be the most important part of therapy, even more important than the treatment modality employed (Brown, 2015). Alliance is regarded as the most researched of all the common factors elements (Wampold, 2015). Broadly speaking, the term alliance encompasses the bond a patient or group has with each other/clinician and agreement about the goals/tasks of therapy. A meta-analysis conducted on over 200 studies including over 14,000 treatments found that alliance is a crucial driving force on the outcome of therapy (Horvath, Del Re, Flückiger, & Symonds, 2011). Another study found that alliance is a significantly negatively impacted by clinicians adopting a "teach and confront" tactic as opposed to a "facilitate and support" tactic (Brown, 2015; Chamberlain, Patterson, Reid, Kavanaugh, & Forgatch, 1984). In concordance with the feedback received from the interviews, evidence suggests that building group cohesion through building on common factors (such as alliance) may decrease resistance and positively impact treatment outcomes. Suggestions for program development in light of this feedback and research findings will be further discussed in the recommendations section.

Peer-ran nature. In the interviews that were conducted, a major theme arose about how the current and former Choices participants felt that the peer-ran nature of the program was not effective. Many of the participants who endorsed this aspect of the program being ineffective reported feeling uneasy about taking advice from someone who is also incarcerated about how to avoid recidivism/relapse. Unfortunately, there is limited research currently published on the efficacy of peer-ran interventions for substance use disorders in jails. Of the articles that were

discovered documenting the effectiveness of peer-ran treatment in forensic mental health, the peer facilitators were not incarcerated while providing treatment and had received formal training to disseminate the treatment. Additionally, of the studies that were conducted, they often were unable to attribute peer interventions to positive outcomes because they often were also in the presence of more formalized treatment programs (Tracy & Wallace, 2016). Further, in studies where patients who were receiving peer facilitated interventions had a self-selection bias (Tracy & Wallace, 2016). In Choices, the peer facilitators are called "mentors" and receive no formal training on how to promote mental wellness or maladaptive behaviors. Instead, they are expected to uphold the rules/expectations of the program, aid in maintaining the daily schedule, and to offer "pull ups" to those who aren't abiding by the program's expectations. Many of the women who were interviewed felt that they shouldn't be told what to do by other women who are in a similar predicament that they are in. Historically, substance abuse treatment has often included aspects of peer support or peer facilitated interventions (i.e.: Alcoholics Anonymous, Narcotics Anonymous, sober living communities, etc.). It is a largely understudied form of treatment to have peer facilitated interventions disseminated in forensic settings as they are a vulnerable population with a set of unique needs and dangers in treatment. Among some of the many risks in offering peer facilitated treatment in forensic settings are: 1) lack of empirical evidence supporting the efficacy of peer vs. professional delivered interventions, 2) risk of breeching confidentiality, 3) and how providing treatment might diminish the efficacy of the peer's treatment (Devilly et al., 2005). In light of the many possible ethical pitfalls, there is a vast lack of empirical evidence supporting peer-ran substance abuse treatment in forensic settings. There is also little evidentiary support pointing to the efficacy of AA/NA being in part due to its

peer-ran nature. With these findings in mind, recommendations for program enhancement can be found at the end of this chapter.

Not enough time alone. The jail environment is, inherently, a chaotic one. People are constantly milling around, talking, yelling, laughing, going to court, going to medical appointments, attending classes, getting rehoused, getting searched, sent to prison, and occasionally verbal and physical fighting. As a result, silence is a rare, and often a valued, commodity. As you can see in Appendix A, the Choices curriculum is not short of scheduled activities. What isn't captured in the schedule is the hourly safety and security checks custody staff completes throughout the night, medical appointments, attorney visits, and various unforeseen events. Jail inmates rarely experience prolonged complete silence, time alone, and even more rarely, silence and time alone concurrently. One of the expectations of the Choices program is that all participants spend all of their available time outside of their cell- either in the shared space on the pod floor, on the outdoor recreation yard, in groups, or with Choices counselors. In the interviews conducted, a theme arose that reflected their desire to have more time alone. Some of the interviewees detailed how exhausting it can be to meet the requirements of constant social interactions daily and to not have the opportunity to engage in self-care activities in solitude. In correctional institutions, there are, generally speaking, only three ways a person may be placed in solitude: 1) because they are in a protective custody and must be housed separate from others for their safety, 2) they have violated jail policy and are housed alone for the protection of the safety and security of the facility, 3) they have been identified as being at elevated risk for a suicide attempt and must be housed in a cell with limited access to means to attempt suicide/self-harm. Research on solitude in custody settings demonstrates powerful negative effects on people. Negative effects include, but are not limited to, increased probability

of engaging in self-harm behaviors, increased probability of violent acting out, exacerbation of preexisting mental health symptoms, and development of new mental health symptoms. Inmates reprimanded by solitary confinement are 6.9 times more likely to engage in self-harm than those who were not (Kaba et al., 2014) and 50% of prison suicides occur in solitary confinement (Goode, 2015). Removing most interpersonal contact, decreasing structure in daily activities, and increasing isolation exacerbates mental health symptoms and provokes reoccurrence (Metzner & Fellner, 2010). With this evidence in mind, it is natural for one to believe that placing inmates in environments void of social interactions should be avoided at all cost. The aforementioned studies and resulting findings reflect data on inmates placed in solitary confinement. Those studies are not reflective of outcomes of inmate voluntary solitude during the course of their day which is otherwise filled with therapeutic programming and social activities. There is a vast body of data on the detrimental effects of involuntary solitude and fewer data on the benefits of voluntary solitude. This poses an area for potential future research- effects of voluntary moments of solitude on mental health in correctional settings. It will be recommended at the end of this chapter that time be provided for participants to explore and practice new coping skills both with others and alone.

Limitations

Of the limitations noted in the collection of the qualitative data, the most notable were sampling bias, response bias, and selective memory as it applies to self-reported data. The women that were referred to this study were referred by current Choices counselors- as such, a sampling bias occurred. The women that were referred had and have been in touch with the Choices counselors post-release from custody which could indicate some sort of allegiance to the program and to the counselors, or at the very least, a desire to maintain contact with a sober

community. This sentiment may have skewed the data collected based on their maintained affiliation with the program. By extension, there may have been a notable response bias. The women contacted to participate in this study were informed that the purpose of the interview was to inform program improvement. With no compensation offered to interview participants, it could be hypothesized that their participation was secondary to their desire for the program to improve and to talk about their experiences. A response bias may have occurred in the sense that participants may have felt an increased desire to speak about their experiences in the program to help future Choices women. Lastly, as is with any self-report data collection, there may have been an issue with selective memory. As is with all memories- the longer the subject is removed from the event, the less likely the memory is to be accurate. Subsequently, there was an inherent selective memory bias for the women who were former participants in Choices. The limitations noted in this portion of the study could have been circumnavigated through random sampling and through interviews occurring more closely to time of discharge from the program. As with any study, limitations will arise. With this study, it is believed that even with the limitations that are evident in the design, the data gathered still provide important information for program development because the motivation for the women to participate in the interview is likely due to their desire for the program to improve.

Chapter 5

Quantitative Results

While the qualitative portion of this dissertation sought to determine the strengths and weaknesses of the Choices program through interviews of current and former Choices participants, the quantitative portion of this dissertation sought to determine to what extent the program is achieving their goals. The goal of the program is to decrease rates of recidivism through decreasing criminogenic thinking, decreasing severity of depressive symptoms, increasing treatment engagement, and altering maladaptive patterns of behavior. Treatment engagement, depression, and criminogenic thinking measures were distributed and analyzed to determine the effectiveness of the program. Additionally, demographic surveys were collected to determine any significant effects on the measures collected and to provide further data on how to develop the program further. It was hypothesized that criminogenic thinking would decrease from intake to discharge, that treatment engagement would increase from intake to discharge, and that depression would decrease from intake to discharge. Exploratory analysis was then performed to determine what, if any, demographic variables impact the outcomes of those aforementioned measures. Let's start by reviewing the results of the demographic data that were collected.

Results

The following summary of the demographic data can also be found in chart form in Appendix H. It is important to note that not all participants were able to complete the measures as it is common that people are released from jail without adequate notice to complete data collection. Additionally, some participants did not complete all questions on the demographic

questionnaire which lead to different sample sizes for different variables. Limitations of this data collection will be expounded upon later in this chapter.

Sample sizes of each of the demographic variables varied. As described earlier, some participants chose to not or were not able to respond to some of the questions on the demographic survey. Of the demographic data that were successfully collected for this study, 59.35% of the women were aged 26-40 years (n=157). Of the 154 women that answered the question about marital status, the majority of the women identified as single (74.83%). All 158 of the women answered the question about ethnicity and the majority identified as white demographic surveys collected as white (36.12%). As was with the ethnicity question, all women answered question about number of children, level of education, and employment status (n=158). Most women identified as having one or more children (69.42%) and most identified as having some college education (36.12%), and as currently unemployed (66.87%). All women when presented with the opportunity to write-in their gender identity answered the question and identified as female. Of the 151 women who answered the sexual orientation question, the majority, 79.61%, of women identified as heterosexual. Of the 144 participants that reported the number of times they were incarcerated, 54.14% had been incarcerated five or more times. Of the 154 participants that reported the number of times they have participated in the Choices program, 53.24% have participated only once. The majority of Choices participants reported having Medi-Cal or Medi-Caid for insurance: 81.16%. The demographic survey allowed women to fill-in their drug or drugs of choice and the majority of 73.41% reported using stimulants (crack, cocaine, methamphetamine, amphetamine). Lastly, 52.57% stated that their criminal charges were for non-violent crimes. The impact that these variables had on treatment outcomes will be reviewed in the exploratory analysis section.

Sample size of the PHQ-9 main analysis during intake and discharge was 38 and 24, respectively. Sample size of the TCU-ENG main analysis during intake and discharge was 164 and 63, respectively. And sample size of the TCU-CTS main analysis during intake and discharge was 156 and 49, respectively.

Main Analysis

Mean score of treatment engagement during intake was 38 whereas the mean score upon discharge was 41. Results of a mixed-effects ANOVA indicated that treatment engagement significantly increased from intake to discharge ($F(1, 139.90)=19.29$, $p<.001$, $eta^2=.12$). Mean score of depressive symptoms upon intake was 11 and upon discharge it was 6. Statistical analysis demonstrated depressive symptoms significantly decreased from intake to discharge ($F(1, 35.33)=7.25$, $p=.011$, $eta^2=.20$). Mean depression scores at discharge reflect mild severity of depressive symptoms. Although there was an overall decrease in criminogenic thinking from intake to discharge, this decrease was not statistically significant ($F(1, 89.99)=1.66$, $p=.201$, $eta^2=.02$). Mean criminogenic thinking score during intake was 21 and during discharge it was 20. Statistical analysis was not completed for subscales of the TCU-ENG nor the TCU-CTS as the subscales represent overall constructs that together represent criminogenic thinking and treatment engagement. Hypotheses for these findings will be described in the discussion section of this chapter.

Exploratory Analyses

There were no significant effects of marital status, race, or ethnicity on change in any of the measures from intake to discharge. Although there was no significant effect of education on change in treatment engagement or criminogenic thinking from intake to discharge, education interacted with time point (intake vs. discharge) to predict change in depressive symptoms ($F(1,$

21.50)=5.58, p=.028, eta^2=.16). Among participants with more education (mean of education + 1 standard deviation, equivalent to at least "some college"), depressive symptoms significantly decreased from intake to discharge (β=0.51, SE=0.06, t(22.20)=3.73, p=.001). In contrast, among participants with less education (mean of education - 1 standard deviation, equivalent to at least high school or less), depressive symptoms did not significantly change from intake to discharge. Current literature on the relationship between educational attainment and depressive symptoms illustrate a tendency for depression to decrease as educational attainment increases as education tends to have a positive correlation with economic stability and wealth. A more thorough description of this phenomenon will be provided in the next chapter. As seen in Appendix I, mean depressive symptoms at intake and discharge are plotted for those with and without at least some college education.

There were also significant effects of age on change in treatment engagement and change in criminogenic thinking. First, age interacted with time point (intake vs. discharge) to predict change in treatment engagement (F(1, 103.35)=14.09, p<.001, eta^2=.19; see Appendix J). Follow-up contrasts indicated that whereas treatment engagement significantly increased among 26-40-year-olds from intake to discharge (**26-40:** β=0.43, SE=0.06, t(99.14)=7.31, p<.001), there were no significant changes in treatment engagement from intake to discharge among 18-25-year-olds or among 41-64-year-olds. At intake, 26-40-year-olds did not differ from participants in the other two age groups in terms of engagement. However, 26-40-year-olds evidenced significantly higher treatment engagement at discharge than participants in the other two age groups (**26-40 vs. 18-25:** β=0.50, SE=0.13 t(184.83)=3.82, p=.001; **26-40 vs. 41-64**: β=0.48, SE=0.12, t(188.56)=3.98, p<.001). There is a wealth of research on the tendency for people to be less frequently involved with the criminal justice system, engage in fewer criminal behaviors,

and attempt to lead more prosocial lives as they get older. Greater discussion of this phenomenon as it relates to these findings, and the findings to be described next, can be found in the following chapter.

Second, age interacted with time point to predict change in criminogenic thinking ($F(1, 85.76)=3.57$, $p=.032$, $eta^2=.07$). Follow-up contrasts indicated that there were no significant changes in criminogenic thinking from intake to discharge among 26-40-year-olds or among 41-64-year-olds. In contrast,18-25-year-olds significantly *increased* in criminogenic thinking from intake to discharge ($\beta=0.26$, SE=0.13, $t(92.21)=2.04$, $p=.044$). At intake, 18-25-year-olds did not differ from participants in the other two age groups in terms of criminogenic thinking. However, as can be seen in Appendix K, 18-25-year-olds evidenced significantly higher criminogenic thinking compared to the other two age groups at discharge (**18-25 vs. 26-40:** $\beta=0.47$, SE=0.18 $t(173.26)=2.56$, $p=.011$; **18-25 vs. 41-64**: $\beta=0.41$, SE=0.18, $t(176.45)=2.31$, $p=.022$). Criminogenic thinking did not differ between 26-40-year-olds and 41-64-year-olds at either intake or discharge. The effect of age on change in depressive symptoms was not tested given low rates of completion of this measure among participants in the youngest and oldest age groups.

Chapter 6

Discussion and Limitations

The purpose of this dissertation was to perform a program evaluation of the Women's Choices program. Hypotheses included that by virtue of participating the program, participant's severity of depressive symptoms would decrease, their criminogenic thinking would decrease, and their treatment engagement would increase. Analyses of the data collected informed us that, in the entire sample, there was a statistically significant decrease in severity of depressive symptoms, that there was a statistically significant increase in treatment engagement, and that there was not a statistically significant change in criminogenic thinking. Further exploratory analysis provided greater insight into how each demographic variable moderated our outcome measures. First, we will discuss the main findings, then we will explore and discuss the findings from the exploratory analyses.

In the context of our literature review, two of our three main findings were expected. Severity of depression symptoms commonly decrease when patients are offered cognitive behavioral therapy, consistency in psychotropic medication regimens, and abstinence from alcohol and other drugs. Depression scores also often decrease from the time someone first becomes incarcerated to when they are then released. The increase in overall treatment engagement was also to be expected because it is common for people to feel increased motivation to maintain sobriety and abstain from criminal behaviors resulting from incarceration. Jail is frequently regarded as a "rock bottom" for many and inspires motivation to not return to jail and subsequently obtain and maintain sobriety. Our hypothesis that criminogenic thinking would decrease as a result of this program was not supported with statistically significant results. Taking into account our literature review, it could be possible that by being around others who

engage in the same categories of criminal behaviors, conversation about "how to not get caught next time" could occur. These conversations may, subsequently, not allow for alteration in frequency or strength of criminogenic thinking. The Choices program offers a unique opportunity, during a precarious time, for women in this jail to take advantage of substance use and mental health treatment. These situational variables may play an impact in the main findings we discovered. Our exploratory analysis offered more specific data which allowed for more discerning interpretation of the main findings.

The exploratory analyses, in sum, described statistically significant changes in the following groups on the following measures: 18-25 year-old women experienced increase in criminogenic thinking from intake to discharge; 26-40 year-old women experienced increase in treatment engagement from intake to discharge; and women with at least some higher education experienced decrease in severity of depressive symptoms. Discussion of the aforementioned results will occur in the order that they appear above. The increase in criminogenic thinking from intake to discharge for 18-25 year-old women and the increase in treatment engagement for 26-40 year old women will be discussed simultaneously as social learning theory and age are major variables used to conceptualize these findings.

To understand why there was a statistically significant increase in criminogenic thinking among women aged 18-25, we must review the phenomenon of antisocial behaviors decreasing with age. It has largely been accepted as fact, appearing in the literature as early as 1831, that there is a strong relationship between frequency of criminal behavior and age (Ulmer & Steffensmeier, 2014). It is also understood that the negative correlation between age and frequency of criminal behavior holds true across genders (and with some controversy, across most other identity spheres; Ulmer & Steffensmeier, 2014). While the negative correlation

between age and frequency is robustly supported in the literature, the reason for it is more widely disputed. As is a cornerstone in many theoretical debates about the epidemiology of various psychological phenomenon- the debate of nature v. nurture also arises in the context of criminal behaviors decreasing with age. Some researchers believe that the decrease in criminal behavior over time is explained by biology while others believe it is explained by social reasons. Most popularly, the decrease in criminal behavior with age is credited to a combination of three major influences: biology, physical environment, and social environment (Ulmer & Steffensmeier, 2014). It is important to understand how each of these major influences plays a role in the trajectory of criminal behaviors in the context of a program evaluation so that more mindful grouping of participants can be considered in the case it influences the effectiveness of treatment rendered.

To begin, biological reasons for the decrease in criminal activity with age include decrease in testosterone, greater development of the prefrontal cortex, and decreased physical strength/stamina/speed (Ulmer & Steffensmeier, 2014). It is thought that increased levels of testosterone are linked to greater aggression and thus greater likelihood of involvement in violent crimes. As testosterone decreases with age, it is hypothesized that aggression and violent crimes decrease as well. The link between testosterone and aggression is also thought to be one reason why men commit crimes at greater rates than women do (Ulmer & Steffensmeier, 2014). For the purposes of this dissertation, we focused on the development of the prefrontal cortex and decreased physical strength/stamina/speed as it is more applicable to women than high levels of testosterone. Development of the prefrontal cortex accompanies improvement in executive functioning, decreased risk-taking, and greater impulse control (Farrington, Loeber, & Howell, 2012). This suggests that as people age, they are more likely to be able to make decisions that are

not criminal in nature. People who continue to commit crimes in older age are more commonly heavily involved in criminal organizations, are high-ranking decision makers (or "shot callers"), and are less likely to physically carry out criminal behaviors themselves (Ulmer & Steffensmeier, 2014). As people age, their physical capabilities decrease which makes them less ideal candidates to criminal organizations to complete criminal tasks and makes them less likely to choose to engage in physically demanding criminal activities on their own (out of fear of failure and subsequent law enforcement contact) (Ulmer & Steffensmeier, 2014).

In conjunction with biology, physical and social environments are thought to facilitate criminal behavior as well. Jail is a unique physical environment which can cultivate problematic social learning. Social learning theory, as was originally conceptualized by Albert Bandura in 1971, asserts that people learn how to react and respond to various stimuli through observation of other people interacting with the same stimuli. The processes underpinning the observations and subsequent social learning include: 1) attention to the modeled behavior; 2) retaining the memory of the modeled behavior; 3) physically reproducing the observed behavior; and 4) motivation through reinforcement (Bandura, 1971). Social learning theory has expanded and been adapted to many different populations, including jails and prisons. Social learning was widely accepted into the study of forensic psychology in 1973 through a publication written by Ronald Akers: "Deviant Behavior: A Social Learning Approach." Today, social learning encompasses four concepts: 1) differential reinforcement; 2) imitation; 3) definitions; and 4) differential association. Differential reinforcement is defined as degree, frequency, and probability of reinforcement- most influential is social reinforcement. Imitation describes how a person repeats the behavior. Definitions as it applies to social learning encompasses what the person determines to be acceptable v. unacceptable as it relates to their learned values as is

created through differential association. Differential association encompasses four subconcepts: timing (the younger the association occurs, the more influential it is), duration of association (longer duration is more influential), frequency of association (more frequent is more influential), and nature of contact (closer association like family is more influential). In jails and prisons, young people are exposed to "criminal role models" whom indoctrinate deviant behaviors as "acceptable" whom also provide advice on how to "not get caught." Colloquially speaking, these "criminal role models" are widely admired and are even often assigned a term of endearment: "OG" (an abbreviation for "Original Gangster" first used in gangs to describe the older/wiser members, now is widely used to describe someone who has a long standing history with criminal organizations and/or the criminal justice system who is regarded as highly experienced and knowledgeable in criminal behavior and culture). Jails and prisons are physical environments that often house a pro-crime culture.

It could be hypothesized that the results of this study which reflect an increase in criminogenic thinking for women aged 18-25 and an increase in treatment engagement for women aged 26-40 are a reflection of how young people are particularly susceptible to (anti-) social learning and how people are less inclined to commit crimes as they age. The older people that are in jail/prison are more commonly prestigious members of criminal communities and are thus more influential in social learning to younger people.

The finding that higher education has some impact on depression decreasing with participation in Choices is not surprising as higher levels of educational attainment is thought to be a protective factor against depression and anxiety (Ross & Mirowsky, 2006). As educational attainment increases, so does a person's sense of having power over their financial/social position. With less educational attainment, it is more common that people have a sense of

helplessness and powerlessness over their financial/social position. It could be theorized that depression scores decreased for people with higher educational attainment from intake to discharge because they had greater hope for the future as it pertains to having more job opportunities as a result of being more educated. We would also expect severity of depressive symptoms to decrease from intake to discharge regardless of intervention provided. One limitation identified of this study is that we can't reliably attribute the decrease in depression to the Choices program. By nature of becoming incarcerated people are often more depressed and by nature of being released from jail people are often less depressed. The statistically significant finding that there was a decrease in severity of depressive symptoms may be conflated with onset and termination of incarceration.

Limitations

As was briefly described earlier, there were some limitations in data collection. Some women did not respond to all questions posed on the demographic questionnaire. The demographic questionnaire also has structural limitations: the marital status answer options did not include "divorced", the level of educational attainment answer options were visually difficult to separate and had no definitions, employment status did not include government assistance options, and the accused crime question did not allow for a combination of violent, non-violent, and drug related charges or for probation/parole violations. Obtaining discharge data for the PHQ-9, TCU-ENG, and TCU-CTS was difficult because some women were released from custody before those measures could be completed. It is recommended that future researchers administer the measures throughout the incarceration to decrease the probability of not capturing discharge data. Administering the measures throughout the incarceration could also more accurately measure the impact of the program on those scales instead of incorrectly capturing

change in mood and outlook as it relates to re-entry into the community. Every study has its limitations and it is believed that the limitations reviewed above would not nullify the current findings. It is, however, fodder to improve future program evaluations.

Chapter 7

Recommendations

In sum, strengths of the program that were identified by current and former participants were: 1) Seeking Safety groups, 2) Social Justice groups, and 3) Parenting groups. There were mixed opinions about the "issues groups"- some identified the groups as a strength, and others identified it as a weakness. Weaknesses discussed in these interviews were identified as: 1) lack of group cohesion, 2) the peer-ran nature, and 3) not enough time alone. Through the themes that emerged in the interviews, the results of the quantitative data, and a review of current evidence-based treatments, the following recommendations are made for further growth of Choices. To integrate more evidence-based treatment groups such as Cognitive Behavioral Therapy and decrease usage of groups that no longer have evidentiary support. This suggestion is made in response to participant feedback and in conjunction with the finding of no statistically significant change in criminogenic thinking for the overall sample collected. It is also suggested that group cohesion be bolstered by strengthening common factors. By strengthening group cohesion, it is believed that treatment engagement and motivation to maintain change will improve (addressing both the concerns voiced in the interviews and the statistical finding there was little change in treatment engagement for the younger and older cohorts of participants.) It is also suggested that there be an alteration program culture of being peer-ran. Lastly, it is recommended that there be time to foster growth of participants' self-care repertoire. It is believed that by increasing participants' adaptive self-care repertoires, they will be more likely to maintain their decrease in severity of depressive symptoms and challenge urges/impulses to abuse substances. Enhancing the participant's self-care repertoire may also be established, when indicated, via intensive

individual therapy. The following section of this dissertation will detail the reasons for the aforementioned recommendations.

Evidence-Based Treatment Groups. Through review of the interviews, Choices curriculum, and literature review, it is recommended that the curriculum be amended to include groups that are evidence-based for incarcerated women with dual-diagnoses. The current curriculum already includes Seeking Safety groups and parenting groups which are regarded as evidence-based and effective in treating trauma and substance abuse and improve parenting skills in this population. The current body of literature also demonstrates a strong case for the use of Cognitive Behavioral Therapy (CBT). CBT has been found to be efficacious in long- and short-term therapies for an abundance of different mental health disorders and in the alteration of maladaptive behaviors. CBT is adaptable to the different needs of the clients, is easily disseminated in a group setting, and promotes ongoing treatment in the patient long after the formal therapy is terminated. Use of CBT, Seeking Safety groups, and addressing discharge planning (which is also a fundamental part of the Choices program) can lend to further improvement in recidivism rates, longer lengths of sobriety for participants, and decreases in criminogenic thinking/depression. It is also recommended that issues groups be used less frequently (if not at all) as current literature no longer demonstrates that attack therapy is effective or appropriate. The feedback about lack of group cohesion and a dislike for the peer-ran nature of the program from current and former Choices participants also lends evidence to minimal value issues groups hold. It could also be further hypothesized that issues group may perpetuate criminal thinking through social learning of ineffective communication styles, of ineffective conflict resolution, and of acceptability of personal attacks.

Bolstering group cohesion. As was already discussed, lack of strong group cohesion was a major theme that was raised in the interviews conducted. The fundamental principle driving many issues groups is that participants are tasked with confronting other participants with maladaptive behaviors they have observed them engage in, an intervention they refer to as "pull ups." It was illustrated earlier in the literature review that common factors between patient/clinician, patient/group, and group/clinician have been found, in some studies, to be more important than the treatment modality itself. So, while it is important to provide patients with evidence-based treatment, it is also important to foster a therapeutic relationship that allows for strong alliance and agreement on goals/tasks of therapy. By adopting a "facilitate and support" tactic rather than a "teach and confront" tactic (as is frequently used by participants and counselors), the Choices participants may endorse higher treatment engagement, greater group cohesion, and increased readiness for change. The culture and expectation of the program now is to have women note every time another participant does something "bad" and confront them about it in a group setting. The confrontation that occurs regularly in the program may be a contributing factor to the low sense of group cohesion that was illuminated through the interviews. One way to develop group cohesion is to adopt a supportive culture where participants and clinicians refrain from using "pull ups" and instead practice greater empathy.

Decrease peer-facilitation of interventions. Aside from in issues groups when participants tell other participants about what they're doing incorrectly, the counselor-chosen Choices "mentors" are also expected to be the upholder of the program rules and to assign daily tasks. Mentors are also expected to report to the counselors on other's behaviors. Many of the interview participants reflected on how they felt it was inappropriate for someone, who is also incarcerated, to be giving them direction and/or advice. It is recommended that some of the peer-

facilitated aspects and duties of the program be reallocated. By not allowing participants to intervene in the daily activities of others, they are allowed more time and energy to focus on their psychological growth and developing sobriety. The Choices program has adopted from Delancey Street a phrase to describe their peer-facilitation expectations: "each one, teach one." It suggests that everyone has something to learn from someone and teach someone. This sentiment is one that is also largely adopted in many peer-support groups such as AA/NA groups. It is important to allow for participants to share what coping skills have worked for them in managing various mental health symptoms and urges to engage in maladaptive behaviors. It would be a great disservice to all future Choices participants to prohibit the "each one, teach one" rhetoric and way of operating. In fact, many participants feel it adds to the overall feeling of togetherness that some Choices alumnae hold. What should be shifted in the program is the hierarchy that develops within the program by use of mentors that is alienating to some participants and diminishes overall cohesion. Propensity of disseminating "advice" on criminal behaviors should also be addressed and heavily monitored as to not create a culture where people fall victim to criminal social learning.

Growth of self-care repertoire. It is a rule in the Choices program that you are expected to be out of your cell and interacting with other Choices participants all day, every day. Women who do not adhere to this expectation often receive "pull ups" in issues groups by peers and confronted by counselors about this behavior. While for some people self-care involves interacting with others and distracting by being social, for others self-care is the opposite. By not allowing women to spend time alone during the day, they are not able to take advantage of an opportunity to try novel coping skills. Jails and prisons are unique in that incarcerated people rarely get a moment alone and rarely can indulge in silence. Jails and prisons are also unique in

that it can provide a person with an environment that is free from temptation to use drugs/alcohol (it is important to disclose that there are, of course, instances where those temptations are available to current inmates). By removing the temptation to engage in maladaptive behaviors that surrounds many of these women daily in the community, they are afforded an opportunity to explore what feelings emerge in the absence of drugs/alcohol, and how to cope with them healthier ways. For some, that might mean taking time to read on their bunk, meditate, or color by themselves. With the temptation of using illicit drugs and alcohol removed, it also may be prudent to offer more intensive and regular individual therapy when indicated. In thinking of distribution of resources of clinicians able to offer the individual therapy, it is suggested that the particularly vulnerable 18-25-year-old may be offered extra resources (given the finding that they are more likely to experience an increase in criminogenic thinking by discharge.) By banning the exploration of solitary self-care activities, participants may be robbed of finding a truly effective coping skill and bolstering their self-care repertoire. It is suggested that the Choices program encourage self-care between groups exploration of new self-care activities and be accepting of whatever form that may take.

Practically speaking, the aforementioned recommendations may prove to be difficult to implement and sustain. It is suggested that trainings and in-services be offered by clinicians already hired within the jail's forensic mental health team. Additionally, it may be effective to have current service providers observe the evidence-based treatment groups that are currently being offered within the jail to gain further exposure to the therapy. These suggestions may offer a cost- and time-effective way to address a lack of training that may be present.

Chapter 8

Conclusions

It is widely accepted that current and former inmates (of jail and prison) are grossly underserved and are a particularly vulnerable population. Through the review of the literature, we learned that the United States incarcerates more people than any other country in the world, that our recidivism rates are high, and that there are too few programs available to people before, during, and after incarceration to ameliorate these alarming rates of incarceration/recidivism. The goal of this dissertation was to conduct interviews with former and current Choices participants, to analyze quantitative data that were collected pre- and post-participation in the program, and to complete a thorough literature review to inform program development. It was the hope in completing this dissertation that the findings would contribute to the growth of the Choices program and would contribute to the growing body of research on efficacious treatment modalities for incarcerated women with dual diagnoses.

The women's Choices program in San Mateo County has touched many lives, has saved many lives, and has a ripple effect that is further reaching than can ever be accurately conceptualized. It offers women a place to be heard, to be understood, and to get lifesaving support by counselors that are steadfast in their dedication to the program and the people receiving the services. Recommendations made throughout this dissertation are made in hopes that the program continues to grow and that the program grows so that even more women (and men) can receive lifesaving support. Jail and prison, while largely understood as currently not being nearly as rehabilitative as it can be, does and can save lives. Incarcerated women are among the most underserved in our nation and that needs to be addressed in future research. By beginning the exploration of what treatments are effective in helping decrease maladaptive

behaviors and increase overall mental wellbeing in jails and prisons, we can begin to increase the possibility of rehabilitative incarcerations at higher frequencies.

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Appendix A

Consent Form

We are interested in gathering information that will help inform an evaluation of the Choices program. Participation in this study is completely voluntary.

Why are you asking me?

We are inviting women that have participated in the Choices program. You were referred to this interviewer by a Choices counselor.

What will I be doing if I agree to be in the study?

You will be asked to answer 7 questions about what you think the Choices program could improve on and about what they do well. The interview will be de-identified and asks questions about changes you would make if you could to the Choices program. No individual responses will be shared with any of the staff, and your responses will be part of an overall summary that is put together for this study.

Is there any audio or video recording?

Yes, you will be audio recorded so that I can then transcribe your answers for feedback to the program director and counselors. Your recording will be stored in a locked cabinet and deleted as soon as I transcribe it. Your name and identifying information will not be on the recording. Direct quotes will not be shared with the program director or counselor, instead summaries will be provided from all the interviews that are conducted.

What are the dangers to me?

Risks to you are minimal, meaning they are not thought to be greater than other risks you experience every day. Sharing your opinions about treatment may make you anxious or bring back unconformable memories, if this occurs, please inform the researcher, Alexa, to discuss them. You may also contact the IRB at the numbers indicated above with questions about your research rights.

Are there any benefits to me for taking part in this research study?

Your participation in this study will inform how the Choices program can improve.

Will I get paid for being in the study? Will it cost me anything?

There are no costs to you or payments made for participating in this study.

How will you keep my information private?

Any personal information provided will be de-identified. If personal information is provided during the interview, it will be deleted as soon as possible. Pseudonyms, or fake names, will be

used during the interviews to protect confidentiality. Recordings of interviews will be kept in a locked cabinet. The recordings will be transcribed as soon as possible, and will be deleted immediately thereafter. The information you provide will be part of a report that will not include identifying information. The goal of the study is to provide information about the strengths and weaknesses of this program.

What if I do not want to participate or I want to leave the study?

You have the right to leave this study at any time or refuse to participate. If you do decide to leave or you decide not to participate, you will not experience any penalty or loss of services you have a right to receive. If you choose to withdraw, any information collected about you before the date you leave the study will be kept in the research records for 36 months from the conclusion of the study and may be used as a part of the research.

Other considerations:

If the researcher learns anything which might change your mind about being involved, you will be told of this information.

Role	**Name**	**Email**	**Phone Number**
Researcher	Alexa	ChoicesResearcher@gmail.com	650-503-4205
Research Supervisor	Dr. Martinez	dmartinez9@usfca.edu	415-422-4247
Institutional Review Board (IRB)	Dr. Patterson	IRBPHS@usfca.edu	415-422-6061

If you are unable to reach any of the above listed people via the contact information provided: submit an inmate request form, select the "other" option on the top of the sheet and write on the blank line "Shivika for Choices Research", you can then write a brief summary of your concern in the comments section of the document if you feel comfortable doing so. Shivika is the mental health supervisor at Maple Street Correctional Center. She will forward your request to Alexa, the researcher on this study.

Voluntary Consent by Participant: By signing below, you indicate that:

- This study has been explained to you

- You have read this document or it has been read to you

- Your questions about this research study have been answered

- You have been told that you may ask the researchers any study related questions in the future or contact them in the event of a research-related injury

- You have been told that you may ask Institutional Review Board (IRB) personnel questions about your study rights

- You are entitled to a copy of this form after you have read and signed it

- You voluntarily agree to participate in the study entitled: *CHOICES: AN EVALUATION OF A PROGRAM AIMED AT REDUCING CRIMINOGENIC THINKING AMONG INCARCERATED WOMEN*

  Participant's Signature: _____

  Participant's Name: _____

  Signature of Person Obtaining Consent: _____

Appendix B

Choices Daily Curriculum Schedule

Monday

7:30	Pill Call
7:30-7:45	Morning Meeting
7:45-8:15	Aerobics
9:00-11:00	Group Issues
9:00-11:00	GED testing
11:00-12:00	Lunch & Seminar (Current Event)
12:00	Pill Call
1:00-3:00	Breaking Barriers w/ Mike C.
5:00-7:00	Lock Down (Count Time)
7:00-8:00	AA Meeting
7:30	Pill Call
9:00-9:15	Evening Clean-Up
No TV	Radio 98.1

Tuesday

7:30	Pill Call
7:30-7:45	Morning Meeting
7:45-8:15	Aerobics
9:00-11:00	Projects (Sewing)
11:00-12:00	Lunch & Seminar (Book Review)
12:30-3:00	Projects (Sewing)
5:00-7:00	Lock Down (Count Time)
9:00-9:15	Evening Clean-Up

Thursday

7:30	Pill Call
7:30-7:45	Morning Meeting
8:00-10:00	Domestic Violence/Parenting w/Karina
11:00-12:00	Lunch & Seminar (Concepts)
12:00	Pill Call
1:00-3:00	Vocabulary w/Betty
3:30-7:00	Communication Class w/Ginger
5:00-7:00	Lock Down (Count Time)
7:30-8:00	Pill Call
9:00-9:15	Evening Clean-Up
	Radio 96.5

Friday

7:30	Pill Call
7:30-7:45	Morning Meeting
7:45-8:15	Aerobics
8:00-11:30	Projects (Sewing)
9:00-10:30	Unlock Your Thinking w/Adrian M
11:00-12:00	Lunch & Seminar (History)
1:00-3:00	Projects (Sewing)
1:00-3:00	HIV Prevention (4rd week)
5:00-7:00	Lock Down (Count Time)
7:00	Pill Call
9:00-9:15	Evening Clean-Up

Radio 107.7

Wednesday

7:30	Pill Call
7:30-7:45	Morning Meeting
8:00-11:00	Seeking Safety
11:00-12:00	Lunch & Seminar (Current Events)
1:30-3:15	Resume Workshop w/Peter
5:00-7:00	Lock Down (Count Time)
7:00-8:00	NA Meeting
9:00-9:15	Evening Clean-Up

No TV

Radio 102.9

Radio 95.7

Saturday

7:30	Pill Call
9:00-9:30	Morning Meeting
10:00-11:00	ESL Class
12:00-1:00	Mentor/Mentee Meeting
1:00 - 2:30	WRAP group
7:45-8:00	Evening Clean-Up

Radio 100.3

Sunday

Pill Call 7:30 AM, 12:00 Noon, & 7:00 PM

T.V. after 11:00 AM.....Evening Clean-Up 7:00 PM

7:30-8:30 Double Scrub/Sharps

Appendix C

Texas Christian University- Criminogenic Thinking Scale

	Disagree Strongly (1)	Disagree (2)	Uncertain (3)	Agree (4)	Agree Strongly (5)
1. You get upset when you hear about someone who has lost everything in a natural disaster.	O	O	O	O	O
2. You are locked-up because you had a run of bad luck.	O	O	O	O	O
3. The real reason you are locked-up is because of your race.	O	O	O	O	O
4. When people tell you what to do, you become aggressive.	O	O	O	O	O
5. Anything can be fixed in court if you have the right connections.	O	O	O	O	O
6. Seeing someone cry makes you sad.	O	O	O	O	O
7. You rationalize your actions with statements like "Everyone else is doing it, so why shouldn't I?"	O	O	O	O	O
8. Bankers, lawyers, and politicians get away with breaking the law every day.	O	O	O	O	O
9. You have paid your dues in life and are justified in taking what you want.	O	O	O	O	O
10. When not in control of a situation, you feel the need to exert power over others.	O	O	O	O	O
11. When being asked about the motives for engaging in crime, you point out how hard your life has been.	O	O	O	O	O
12. You are sometimes so moved by an experience that you feel emotions you cannot describe.	O	O	O	O	O
13. You argue with others over relatively trivial matters.	O	O	O	O	O
14. If someone disrespects you then you have to straighten them out, even if you have to get physical.	O	O	O	O	O

15. You like to be in control.	O	O	O	O	O
16. You find yourself blaming the victims of some of your crimes.	O	O	O	O	O

	Disagree Strongly	Disagree	Uncertain	Agree	Agree Strongly
	(1)	(2)	(3)	(4)	(5)
17. You feel people are important to you.	O	O	O	O	O
18. The country's justice system was designed to treat everyone equally.	O	O	O	O	O
19. Police do worse things than do the "criminals" they lock up.	O	O	O	O	O
20. You think you have to pay back people who mess with you.	O	O	O	O	O
21. Nothing you do here is going to make a difference in the way you are treated.	O	O	O	O	O
22. You feel you are above the law.	O	O	O	O	O
23. It is okay to commit a crime in order to pay for the things you need.	O	O	O	O	O
24. Society owes you a better life.	O	O	O	O	O
25. Breaking the law is no big deal as long as you do not physically harm someone.	O	O	O	O	O
26. You find yourself blaming society and external circumstances for the problems in your life.	O	O	O	O	O
27. You worry when a friend is having problems.	O	O	O	O	O
28. The only way to protect yourself is to be ready to fight.	O	O	O	O	O
29. You are not to blame for everything you have done.	O	O	O	O	O
30. It is unfair that you are locked-up when bankers, lawyers, and politicians get away with their crimes.	O	O	O	O	O
31. Laws are just a way to keep poor people down.	O	O	O	O	O

32. Your good behavior should allow you to be irresponsible sometimes.	O	O	O	O	O
33. It is okay to commit crime in order to live the life you deserve.	O	O	O	O	O
34. Prosecutors often tell witnesses to lie in court.	O	O	O	O	O
35. You justify the crimes you commit by telling yourself that if you had not done it, someone else would have.	O	O	O	O	O
36. You may be a criminal, but your environment made you that way.	O	O	O	O	O

Appendix D

Texas Christian University- Treatment Engagement Scale (TCU-ENG)

	Disagree Strongly	*Disagree*	*Uncertain*	*Agree*	*Agree Strongly*
	(1)	*(2)*	*(3)*	*(4)*	*(5)*
Please indicate how much you AGREE or DISAGREE with each statement.					
1. You trust your counselor.	o	o	o	o	o
2. Time schedules for counseling sessions at this program are convenient for you.	o	o	o	o	o
3. It's always easy to follow or understand what your counselor is trying to tell you.	o	o	o	o	o
4. This program expects you to learn responsibility and self-discipline.	o	o	o	o	o
5. Your counselor is easy to talk to.	o	o	o	o	o
6. You are willing to talk about your feelings during counseling.	o	o	o	o	o
7. This program is organized and run well.	o	o	o	o	o
8. You are motivated and encouraged by your counselor.	o	o	o	o	o
9. You have made progress with your drug/alcohol problems.	o	o	o	o	o
10. You are satisfied with this program.	o	o	o	o	o
11. You have learned to analyze and plan ways to solve your problems.	o	o	o	o	o
12. You have made progress toward your treatment program goals.	o	o	o	o	o
13. You always attend the counseling sessions scheduled for you.	o	o	o	o	o
14. Your counselor recognizes the progress you make in treatment.	o	o	o	oo	

	Disagree Strongly Strongly (1)	Disagree (2)	Uncertain (3)	Agree (4)	Agree (5)
15. Your counselor is well organized and prepared for each counseling session.	○	○	○	○	○
16. Your counselor is sensitive to your situation and problems.	○	○	○	○	○
17. Your treatment plan has reasonable objectives.	○	○	○	○	○
18. Your counselor views your problems and situations realistically.	○	○	○	○	○
19. Other clients at this program care about you and your problems.	○	○	○	○	○
20. You have stopped or greatly reduced your drug use while in this program.	○	○	○	○	○
21. Your counselor helps you develop confidence in yourself.	○	○	○	○	○
22. You always participate actively in your counseling sessions.	○	○	○	○	○
23. You have made progress in understanding your feelings and behavior.	○	○	○	○	○
24. Other clients at this program are helpful to you.	○	○	○	○	○
25. You have improved your relations with other people because of this treatment.	○	○	○	○	○
26. The staff here are efficient at doing their job.	○	○	○	○	○
27. You are similar to (or like) other clients of this program.	○	○	○	○	○
28. You have made progress with your emotional or psychological issues.	○	○	○	○	○

	Disagree Strongly (1)	*Disagree* (2)	*Uncertain* (3)	*Agree* (4)	*Agree Strongly* (5)
29. Your counselor respects you and your opinions.	○	○	○	○	○
30. You have developed positive trusting friendships while in this program.	○	○	○	○	○
31. You give honest feedback during counseling.	○	○	○	○	○
32. You can depend on your counselor's understanding.	○	○	○	○	○
33. There is a sense of family (or community) in this program.	○	○	○	○	○
34. You can get plenty of personal counseling at this program.	○	○	○	○	○
35. This program location is convenient for you.	○	○	○	○	○
36. You are following your counselor's guidance.	○	○	○	○	○

Appendix E

Patient Health Questionnaire-9 (PHQ-9)

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks*, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	_____
	Somewhat difficult	_____
	Very difficult	_____
	Extremely difficult	_____

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Appendix F

Demographic Questionnaire

1. Age (circle one): 18-25 26-40 41-64 65+

2. Ethnicity (circle one): White Latina African American Asian American Pacific Islander Biracial Other

3. Marital Status (circle one): Married Single Widowed Separated

4. Number of Children (circle one): 0 1 2 3 4 5+

5. Level of Education (circle one): Some High School or Lower High School Degree/GED Post High School Technical Training Some College College Degree or Higher

6. Employment Status (circle one): Unemployed Employed Unemployed and Looking

7. Drug of Choice:

8. Gender Identity:

9. Sexual Orientation:

10. Number of Times Incarcerated as an Adult (Including this Incarceration):

11. Number of Times in Choices (Including this Enrollment):

12. Type of Insurance (circle one): Uninsured Medical Medicaid Private

13. Accused Crime (circle one): Violent Non-Violent Drug Related

Appendix G

Semi-Structured Interview Questions

"Hi, my name is Alexa, and I will be asking you some questions about your experience in the Choices program. There are no right or wrong answers, and your answers will remain anonymous. No individual responses will be shared with any of the staff, and your responses will be part of an overall summary that is put together for this study."

1. What did you enjoy most, in terms of the programming, in Choices? Prompt: What did you like about the Choices program?
2. What do you wish the program covered? Prompt: What do you think is missing from the Choices program?
3. What did you gain from being in Choices? Prompt: What was the most important thing you learned from Choices?
4. What didn't you like about the program? Prompt: What would you change about the program?
5. What would you like to see removed from the Choices curriculum? Prompt: How would you change Choices, if you could?
6. What specific parts of the program are most helpful? Prompt: What specific groups should not be dropped?
7. What specific parts of the program are least helpful? Prompt: What specific groups could be dropped?

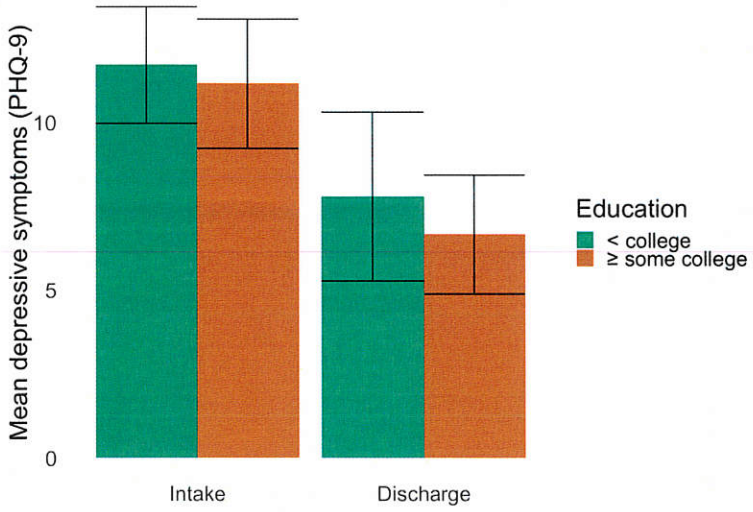
Appendix H

Demographic Data

	Number of Participants	Percentage
Age		
18-25	31	20%
26-40	92	59%
41-64	32	20%
65+	0	0%
Ethnicity		
White	56	36%
Latina	36	23%
African American	10	6%
Asian American & Pacific Islander	11	7%
Biracial or Other	42	26%
Marital Status		
Married	9	5%
Single	116	74%
Widowed or Separated	27	17%
N/A or Declined to State	3	1%
Number of Children		
0	42	27%
1	31	20%
2+	81	52%
N/A or Declined to State	1	.6%
Level of Education		
Some High School or Lower	22	14%
High School or GED	45	29%
Post- High School Education	87	60%
N/A or Declined to State	1	.6%
Employment Status		
Unemployed	105	67%
Employed	13	8%
Unemployed & Looking	33	21%
N/A or Declined to State	4	2%
Drug of Choice		
Depressants	94	41%
Stimulants	116	51%
Other	16	7%

Appendix I

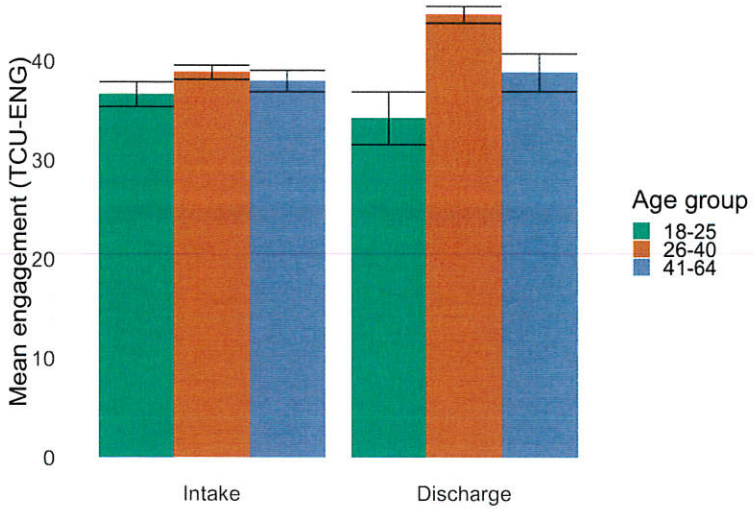
Appendix I. Change in depressive symptoms from intake to discharge by education group



Notes. Error bars are +/- 1 standard error of the mean.

Appendix J

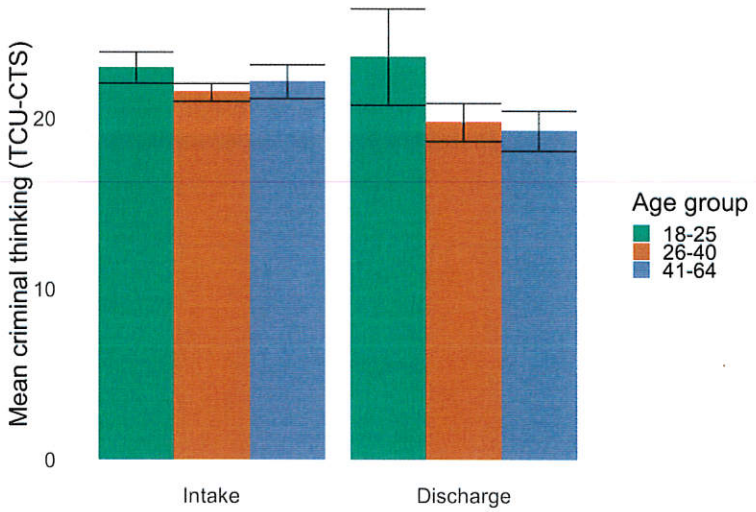
Appendix J. Change in treatment engagement from intake to discharge by age group



Notes. Error bars are +/- 1 standard error of the mean.

Appendix K

Appendix K. Change in criminogenic thinking from intake to discharge by age group



Notes. Error bars are +/- 1 standard error of the mean.